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# Comparative study of innovations on chronic conditions in primary health care in Porto Alegre, Rio Grande do Sul, Brazil, and Ferrara, Italy


Estudo comparativo das inovações sobre condições crônicas na atenção primária em Porto Alegre, RS, Brasil e Ferrara, Itália

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## Abstract

This study compares the main challenges related to innovations in health care concerning chronic conditions perceived by primary care professionals from Porto Alegre, Brazil, and Ferrara, Italy. This is a descriptive exploratory study with a qualitative approach performed in primary care units whose data were collected through semi-structured interviews with professionals from the Local Sanitary Unit of Ferrara and focus groups and semi-structured interviews with workers of the Community Health Service of the Grupo Hospitalar Alegre Conceição of Porto Alegre. Data were discussed using thematic analysis. By analyzing both cases, the main challenges of both professionals and users are innovative practices, difficulties in the organization and management of care, and inefficient training process, which still does not prepare the professional for the new health care model. We conclude that these challenges influence the daily routine of these professionals and discourage the incorporation of innovative practices in the care of people with chronic conditions.

**Keywords:** Chronic Disease; Primary Health Care; Family Health.

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## Resumo

Este estudo visa comparar os principais desafios referentes às inovações na atenção às condições crônicas percebidos por profissionais de atenção primária de Porto Alegre, Brasil, e Ferrara, Itália. Trata-se de pesquisa exploratória descritiva de abordagem qualitativa realizada em unidades da atenção primária, cujos dados foram coletados por meio de entrevistas semiestruturadas com profissionais da Unidade Sanitária Local de Ferrara e grupos focais e entrevistas semiestruturadas com trabalhadores do Serviço de Saúde Comunitária do Grupo Hospitalar Conceição de Porto Alegre. Os dados foram discutidos por meio de análise temática. Colocando em análise os dois casos, destaca-se como desafios, a resistência tanto dos profissionais, quanto dos usuários diante das práticas inovadoras, dificuldades na gestão do cuidado e deficiência no processo de formação, que ainda não prepara o profissional para o novo modelo de atenção. Conclui-se que estes desafios influenciam claramente no dia a dia dos serviços e desestimulam a incorporação de práticas inovadoras no cuidado das pessoas com condições crônicas.

**Palavras-chave:** Doença Crônica; Atenção Primária à Saúde; Saúde da Família.

## Introduction

Chronic conditions are among the main public health issues, resulting in a high number of premature deaths and loss of quality of life in addition to economic impacts for families, communities, and society in general. In Brazil and Italy, chronic conditions are also a major health problem and account for 72% and 92% of the causes of death, respectively (WHO, 2014).

The implementation of care models that adequately respond to chronic conditions is necessary. Given this new agenda, many countries have been reformulating their health systems in recent years, redirecting them to an integrated structure, with a focus on strengthening Primary Health Care (APS) and care for chronic patients. Due to the difficulty of breaking the paradigm observed in health services regarding normative behaviors and the development of interprofessional work, this study aimed to compare the challenges related to innovations in the care of chronic conditions perceived by APS professionals in two cities: Porto Alegre, Brazil; and Ferrara, Italy.

We carried this study in two different spaces: The Community Health Service (SSC) that is part of the Grupo Hospitalar Conceição (GHC) in Porto Alegre, and the Nursing Homes of the Local Health Unit (AUSL) in Ferrara, to assess their similarities and differences. The choice was made based on their current efforts towards the strengthening of primary health care, as well as the introduction of new tools for the management of chronic conditions.

For a better understanding of innovations in the care for chronic conditions, we present, next, changes in the care of people with chronic conditions regarding the APS in both countries. SSC/GHC innovates in the use of health care technologies, investing in changes based on international models and in the Chronic Care Model (MACC). Since 2011, this service has been introducing new tools in the management of chronic diseases in health units, such as sequential and collective consultations by a multidisciplinary team, and the use of supported self-care instruments and stratification according to risks and vulnerabilities. On the other hand, AUSL Ferrara invests in technologies for the care

of chronic diseases based on international models and the specific national plan of the Italian Ministry of Health to fight chronic conditions. It has also focused on 'hands-on' medicine and integrated care pathways, considering new organizational approaches to adjust care responses in the face of the surge of chronic conditions (Mondini, 2015).

In this context, comparative studies that enable the reflection on specific problems in different scenarios contribute to the identification of common issues and the knowledge exchange on how to approach them. They also aim to provide the services with development elements to find new ways of caring for people with chronic conditions in their areas of responsibility.

## Method

This qualitative research of comparative nature was carried out in Ferrara, province of the region of Emilia Romagna, Italy, in 2017; and, later, in Porto Alegre/RS, 2018, as part of a split-site Ph.D. program by one of the authors. Data were compared while considering that the two services have a significant impact on the change of health care for chronic conditions.

The study took place inside SSC/GHC health units, regarded as health care benchmarks for 105 thousand people, and the 3 AUSL Nursing Homes in operation during the research period in Ferrara, which are considered a reference for 354 thousand people. A *Casa di Cura* (Nursing Home) is a health center close to the so-called *Unidade Básica de Saúde* (Basic Health Unit) of the Brazilian National Health System (SUS). In Porto Alegre, the research comprised four health units bound to SSC/GHC.

Data collection in Ferrara took place between April and September 2017. The difficulty for professionals to find open spaces for dialogue due to the lack of a teamwork culture prevented focal discussions. As a result, data collection was based on participant observation and semi-structured interviews with professionals and managers of Nursing Homes. In Porto Alegre, the collection took place between July and December 2018 and was based on participant observation, focal discussions with

healthcare teams, and semi-structured interviews with members of the Centro de Estudos e Pesquisas em Atenção Primária (Cepaps/GHC). We spoke to 11 professionals in Ferrara and held four focal discussions with healthcare teams in Porto Alegre, one in each health unit. We have also interviewed 3 Cepaps/GHC members.

Minayo's thematic analysis (2010) was used during data analysis. It unfolded in three stages: pre-analysis, data investigation, and treatment of the results obtained from their interpretation. Pre-analysis consisted of faithful transcription of the discussions within focal groups and recorded interviews, readings of the material, and data sorting.

Therefore, this analysis was carried out using category framework obtained through an exhaustive and thorough reading of the interviews and focal groups, identifying the similarities, elements, and ideas, reaching the following nuclei of meanings: reluctance in the face of innovative practices, challenges in care management, and professional training. Finally, we sought to unravel the content of the subject, which allowed us to broaden context understanding (Minayo, 2010), as well as the challenges related to these health care services' attentions to chronic conditions in primary care.

The research was approved by the International Health Center, an agency bound to the Università di Bologna. In Brazil, the approval was given by the Unisinos' and GHC's Ethics Committee, under Resolution No. 466/2012 of the National Health Council concerning human beings. In both places, to maintain the confidentiality of the participants, they were called flower names. The interviewees signed the Consent Form and were informed about the disclosure of the study.

## Results and discussion

### Reluctance towards innovative practices

Through thematic analysis, we were able to point out that both health professionals and health care patients are resistant to innovative practices. Facing the transition from the acute care model to the chronic care model is still difficult, which implies

obstacles to the development and consolidation of these practices.

*There is a greater appreciation of individual consultation, to the detriment of innovative practices, activities, and spaces shared with other people. In my perception, there is a culture on the part of the professional, as well as the user, of avoiding participation.* (Flor de Lótus, Nurse – SSC/GHC)

The popular conception believed by most health workers is that health care comes down to individual consultations and procedures. Thus, they do not value new proposals. One factor leading to this situation is the inheritance of the hegemonic “curative” model centered on the disease, which results in the little regard patients and professionals have for the chronic care model.

The predominance of culture arising from prescriptive medicine was also found in the research by Máximo, Souza, and Freitas (2015). According to the author, there is a prevalent belief that taking care of one’s health is the same as going to the doctor and having regular exams. This perception seems to go against the practices of attention to conditions from the perspective of autonomy and empowerment. In their study, Silva et al. (2018) verified the low quality in the care provided for patients with diabetes mellitus and/or hypertension in the APS according to the Chronic Care Model (CCM), showing that the reorganization of the care model oriented to chronic care in the context of the APS seems still distant from its postulates, giving way to traditional biomedical models.

The comparative study by Heidemann et al. (2018) carried out in primary care units in Florianópolis, Brazil; and Toronto, Canada, to understand the organizational experiences within universal public health systems has also found a health care focused on the hegemonic model, which highlights the need to move towards the positive conception of health and social determinants.

AUSL Ferrara’s professionals commented on the reluctance within the group: *The main difficulty is resistance. The nursing home has great potential but relies on its professionals’ motivation to be open-minded. When there are people who do not want*

*to change, changes cannot take place* (Perpétua, Nurse). They have also called our attention while pointing out that the employee retirement process and the arrival of new staff are positive aspects. According to the interviewees, new employees arrive at the Nursing home with greater enthusiasm to carry out proposals that trigger beneficial changes while experienced professionals manifest greater resistance to implementing actions that may reflect in changes in routine.

*The major impediment is the [need for a] change in the professional mindset. There are people of a certain age here who are used to old work schemes and overcoming these schemes takes time. I hope many new people arrive with the will to make changes.* (Narciso, Physician)

In their study on health education to prevent chronic complications of diabetes mellitus in primary care, Salci, Meirelles, and Silva (2018) also identified difficulties for professionals to conduct practices outside the traditional models. The authors observed that the methodological strategies for the practice of activities that included health education actions were weak and limited, as not all team members were involved in the search for comprehensive assistance with the participation of all social actors. They also lacked a broader objective regarding competence development, co-responsibility, and co-participation that aimed at stimulating and developing people’s autonomy for self-care and conscious choices.

A systematic review of the literature on factors that influence the implementation of the CCM identified that the main barriers to its implementation are the organizational culture, the structural characteristics, the communication network, and leadership support (Kadu; Stolee, 2015). Another systematic review on the diabetes chronic care model verified that the use of CCM isolated components might not be enough to improve results; however, greater benefits may arise from interventions that combine all six elements of the CCM (Baptista et al., 2016).

Davy et al. (2015) highlight that the implementation of the model was successful when there was a shared

decision by the team and a recognized need by the organization for continuous quality improvement to support the change. Robusto et al. (2018) also verified that the introduction of the CCM proved to be efficient in reducing costs. A population-based retrospective cohort study carried out in Puglia, Italy, pointed to a reduction in hospitalizations days and costs within a group of people suffering from chronic conditions part of a CCM-oriented care program when compared to individuals who received regular care.

The professionals at AUSL Ferrara highlighted that patients with chronic conditions are still reluctant to understand the importance of protagonism in health care: *Citizens are highly resistant to understand that they are the main actors of their own health* (Primavera, Educator).

This behavior also prevailed in the study by Raupp et al. (2015). Most patients did not report participating in health promotion or prevention activities and sought the unit only for consultations or occasional procedures. Results found in the study by Máximo, Souza, and Freitas (2015) revealed that the individuals most adherent to the idea of health promotion are those who experienced it from an early age; that is, those who learned to take care of themselves and adopt healthy habits, perceiving this as a value introjected early in their lives. According to the authors, adherence to healthy lifestyles, willingness to care, and self-care are social constructs acquired in life.

The difference between acute and chronic conditions is that chronic diseases cannot be cured, only cared for. This means that, even with perfect treatment, people will have to carry the disease for the rest of their lives. In other words, treatment for chronic diseases is not aimed at restoring physical and biological health, but to control symptoms and prevent disease progression in the most severe phases. That is why the treatment of chronic diseases should be understood as a strategy of tertiary and quaternary prevention, maintained throughout life to reduce the chronic effects of the condition and the consequent excessive medication (Tesser, 2017) that are the bases for autonomy maintenance.

However, it is understood that one cannot lose sight of the fact that the person's freedom of choice lies in the background of this entire process and, as such, professionals also need to work with their expectations while dealing with the subject's response. Some believe that taking the medication prescribed by the physician may be the best treatment, knowing that embracing new habits can be as beneficial as the medication. Others use popular therapies to take care of themselves, having a great interest in such practices and guided by empirical and family experiences (Ulbrich et al., 2012).

Considering the health care singularities and the need to individually respect and understand each person and their surroundings, in addition to the uniqueness and multiplicity of people experiencing the process of carrying a chronic condition; health professionals involved in the systematic monitoring of this population should observe all these factors, mainly when taking into account how important it is for people with chronic conditions to receive quality monitoring from the APS (Gómez-Palencia; Castillo-Ávila; Alvis-Estrada, 2015).

The change of both patients with chronic conditions and professionals is not fully controllable, as each person has unique values, conceptions, and ideas. It is a fact that automatic changes in the practice of care are not guaranteed, even after innovations have been successfully implemented. Stepping back from the curative model, as intended by the practices of attention to chronic conditions, is a gradual process. There was an accumulation of initiatives in both cases analyzed, which, although indicative of a change in the quality of care, does not yet constitute a new model.

## Care management

We verified that professionals complained about the rules imposed by management and the need to overcome a history of fragmentation dating back to the origins of the health care systems.

*There is no understanding within management that, as a primary care service, if our main indicator were more than just productivity, our outcome would*



*be hypertensive patients under control and not the number of consultations delivered.* (Estrelita, Psychologist – SSC/GHC)

The importance of ensuring indicators and individual care for people with chronic conditions in the care spaces is well-known. However, these should not be focused on meeting goals regarding the number of hypertensive patients consulted, but on understanding how many of them currently have their blood pressure under control. Through the speeches, we could observe a dissonance between SSC/GHC's stance of introducing managerial changes permeated by a co-management process, and the actual management practice. The subjects point to a conception that values the descending hierarchy of the service organization, reinforcing the hegemonic managerial rationalization.

*There is an extremely demanding culture in terms of consultation productivity, sometimes even in a way slightly dissociated from this change in the care model. I think some of it comes from the tradition of services and the organization itself, which is still fragmented and comprised of people who don't communicate with each other much. It seems that, on the one hand, the service has a project that is clear, but it works only for the people who coordinate it, as sometimes it does not reach the staff.* (Begônia, Interviewee)

Campos (2000) criticized the hegemonic managerial rationality and indicated a method for the analysis and co-management of collectives that seeks to favor the democratization of management in organizations through the formation of organized collectives focused on the production of goods or services and the fostering of the subjects participation in the management of the organization and its work processes. The concept is particularly rich, as it directly affects the hierarchical relationship that historically characterizes health care, emphasizing the productive and emancipatory potential of subjects' participation.

Terra and Campos (2019) observed a similar scenario. There were many complaints about the sorting of activities; they were mainly restricted

to the doctor's office and strict consultation times. Most of the workload concentrated in the office, and most professionals stated that they were unable to plan their routines to work more comprehensively. This finding corroborates Souza's (2015) opinion that, even within the public system, there is a trend towards managerialism inspired by Fordist standards, with the definition of goals and the organization of work happening unilaterally by management.

Corroborating what was said by SSC/GHC professionals, AUSL respondents in Ferrara also pointed to the fragmentation of the health service. In their description, an important consequence to consider are the broadest processes in the history of the Italian National Health Service (SSN): *Fragmentation is strongly present and hard to confront. We need to overcome this barrier, but it is a difficult path due to the whole historical organization of the health system* (Azaleia, Nurse).

It should be noted that the SSN has undergone several reform processes since 1992. The health care system has been increasingly approached from an "entrepreneurial" point of view, giving way to the logic of economic management into the Italian health care system. With Legislative Decree No. 229, of June 19, 1999, the responsibility for the health service was transferred to Regions, which inherits a business-type organization and evaluation. AUSL ('Azienda' Unità di Salute Locale) is the organizational unit responsible for the Italian health service. They are responsible for the provision of health services, management, service evaluation, and sanitary and epidemiological surveillance. Different services are organized vertically within this fundamental structure of the system (Martino et al., 2015).

In Brazil, private initiative is also gaining momentum. The performance of the private sector is motivated by the profit pursued in the sector, and not by solidarity or constitutional rights, which are values inherent to a model of social protection that does not attribute the individual with full responsibility for their health. Thus, its most meaningful actions will be selective towards the share of the population who have access to the financial means to consume its services (Cardoso

et al., 2017). By prioritizing economic interest, the country puts at risk the quality of services required to fully meet the health needs of the population, with negative repercussions on the ESF performance and the organization of the basic health services (Facchini, Tomasi, Dilélio, 2018).

Another important point highlighted by AUSL Ferrara's professionals is the lack of a teamwork culture and the fragmentary co-management through which doctors set themselves apart from the system: *Professionals are not used to working together, especially the core of physicians. It is hard to make them understand that their work is not mono-sectoral, but should forcefully expand* (Érica, Physician).

It is crucial to understand the role of Family Physicians (MdF) within the SSN. MdFs are not civil servants, but free professionals able to work alone from their private offices or inside the Nursing home. Even if they accept to work inside the building, they may refuse to team-up with other professionals who, unlike such doctors, have a contractual obligation to the SSN and answer to the service management (Martino et al., 2015). These particularities within the SSN make it hard for healthcare teams to develop. Out of the three Nursing Homes, none managed to establish real teamwork and the doctors who agreed to transfer within the Nursing Homes have not changed the way they work.

Unlike what is found in AUSL Ferrara, there is teamwork in the SSC/GHC; however, there is no collective responsibility from all professionals in organizing the chronic care practices, even while working in groups, and tasks are fulfilled individually, showcasing the lack of team engagement. *Even with the multidisciplinary training, it turns out that each member of the team performs their activities within their framework, they do not do it together [...] but the innovations propose that we do it together, and that is hard to achieve* (Crisântemo, Interviewee).

Silva et al. (2016), in research on the care of tuberculosis cases according to the elements of the CCM in health units in Paraíba, noted that healthcare teams have the same profile of grouping teams, presenting juxtaposed actions characterized by the fragmentation of work and centralization of actions in which each professional works in isolation within their technical competence.

Although there is some communication between some professionals, it occurs mainly as a sort of technical instrumentalization; a duty to be fulfilled.

Given the above, the way services are organized and how professionals work, in both cases, tends to delay processes of change in care for people with chronic conditions. AUSL Ferrara finds itself in the initial stages, so there are other elements to be addressed, such as the structure of multidisciplinary teams and fragmentary co-management, in which doctors set themselves aside from the system. SSC/GHC, on the contrary, is a consolidated institution; however, the lack of collective responsibility shows that this challenge needs to be faced to improve teamwork.

### Professional training

We found that most participants believe the professional training is still strongly centered on a model that favors individual care based on the biomedical model and enables technical performance, not yet addressing competence with a broader focus on problems concerning the daily routine of services.

*It is necessary to act on the training of professionals, especially doctors. The current formation is very fragmented and poorly done. Training on prevention, education on lifestyles, and work with the community is needed. You could be the best technician or the best doctor in the world, but if you don't involve the community, it doesn't really matter.* (Amarílis, Physician – AUSL Ferrara).

Research carried out by Gómez-Palencia, Castillo-Ávila, and Alvis-Estrada (2015) identified the lack of training by health professionals, which reflected in superficial attention that did not enable the subjects to self-manage their condition.

In Italy, training in primary health care suffers from significant backwardness, which affects the role of the general practitioner in many ways. Contrary to what happens in the rest of Europe, Latin America, the United States, and Canada, there is no academic postgraduate specialization in primary care, but merely a training course whose management is



entrusted to each of the administrative regions in terms of stipulating the number of scholarships, as well as in terms of programming the educational offer, which therefore becomes heterogeneous. Likewise, substantial training in primary care during graduation is still absent in traditional curricula, except for some advanced experience in isolated universities (Becchi; Aggazzotti, 2008).

In some aspects, Primary Care Training in Italy emerges outside the definition given by the World Organization of National Colleges (Wonca), according to which “general medicine is an academic and scientific discipline, with its own educational and research contents; a true clinical activity based on evidence and a clinical specialty oriented to primary care (Wonca, 2011).

Italy’s National Federation of Doctors and General Practitioners supports the urgent need for changes in training based on other models, such as the “hands-on” medicine organized in multidisciplinary teams and based on the physician’s proactive role. It also suggests that basic training should be characterized by professional content that empowers family physicians to guide and accompany the patient in their care journey, in addition to improving the health status of the general population (FIMMG, 2007).

Ferrara and SSC/GHC professionals pointed out deficiencies in the training process, which still does not prepare professionals for the new model of care:

*It is very hard for professionals to stand up for something that they are not trained to do because you will not expose yourself to something that you are insecure about and, concerning chronic conditions, practices are strongly behavioral. So, there is a paradox, as the training available does not include these new proposals (Crisântemo, Interviewee).*

Health education in Brazil is still structured following the disciplinary teaching model and based on biological sciences as its main source of knowledge. Even after over than 10 years of the Lei de Diretrizes Curriculares Nacionais, Almeida Filho (2013) points out that Brazilian universities, attached to their hegemonic regime, still submit students

to training based on closed, less interdisciplinary, and increasingly specialized curricula that are hardly committed to public health policies and with a tendency towards alienation, thus hindering efficient teamwork.

Health professionals training may be undergoing a long period of crisis, but that is not an exclusive issue of the GHC Brazil, or the AUSL Ferrara, in Italy. The Global Independent Commission for the Education of Healthcare Professionals alerts about training weaknesses being common to most countries. Among the main obstacles, the commission highlights the incompatibility between skills and patient or community needs; fragile teamwork; overly technical focus; limited understanding of local contexts; predominant hospital orientation to the detriment of primary care; and lack of leadership empowerment to improve health system performance (Frenk et al., 2010).

In-service training is required to assist in the deficient training of health professionals. Permanent Health Education (EPS) arises as a tool to enable professional contemplation on the achievement of integrality through action-reflection-action; aiming at the articulation of new knowledge in training; changing attitudes, autonomy and motivation of the subject, qualification, and change in care practices (Brasil, 2017). EPS activities in health units at SSC/GHC are carried out monthly, through case study discussions and seminars based on the local reality.

In Italy, the strategy used for professional qualification is the continued education; however, in the way it was conceived, it tends to favor the recognition of *Educazione Continua in Medicina* (ECM) in credits, according to the participation in large expensive conferences, often subsidized by the pharmaceutical industry, with obvious repercussions on the non-neutrality of information (Pisacane, 2008). Continued education sometimes fails to meet the needs arising from work, nor does it adapt its structures and processes to qualify the participants to meet social demands that require technical-operative interventions (Fernandes, 2016).

As a device to foster change and operating mainly on the micropolitics of the work process, EPS is necessary to enable a productive restructuring in Nursing Homes. Inspired by Brazilian experiences,

including GHC's; the International Health Center (CSI), an agency bound to the University of Bologna, EPS is encouraging AUSL Ferrara's Nursing Homes to implement permanent education as a strategy for the requalification of training, assistance, and management practices to small multidisciplinary groups.

In both realities, professionals voiced their concerns about conflicts during professional training. Such conflicts are characterized by the inability to update methodologies and teaching content to reflect the profound changes that took place in recent decades within social and health care spheres. In this sense, EPS needs constant development and encouragement, so that the results perceived may trigger significant changes in work processes. At SSC/GHC, EPS has been tried on since 2008, allowing its insertion within the service in a stronger and more articulated way. In contrast, at AUSL Ferrara, EPS was proposed in mid-2014 and is still regarded as a recent experience.

## Final considerations

Challenges related to innovations in care for chronic conditions in two primary care services within the contexts of two different countries become visible based on this work. Reports from both places demonstrated that there is still resistance to the adoption of innovative practices from both professionals and patients with chronic conditions. Regarding care management, at SSC/GHC we emphasize the focus on management by results, while at AUSL Ferrara there are the difficulties in the development of multidisciplinary teams and fragmentary co-management, in which doctors remove themselves from the system. Another point to be highlighted concerns health services fragmentation.

In both realities, there is still a deficiency in the process of training professionals in the face of the profound changes that took place in recent decades. In return, both SSC/GHC and AUSL Ferrara are investing in EPS to expand the engagement and critical reflection by managers

and workers, so that it contributes to their professional qualification.

Above all, it seems that these challenges clearly influence day-to-day services and discourage the adoption of innovative practices in the care of people with chronic conditions. We hope that this article may empower new reflections, thereby subsidizing the reorientation of the health care production model, with a consequent change in work processes.

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### Authors' contribution

Silocchi conceived the article and collected the data analyzed by Junges, who reviewed the article and approved the version to be published. Martino discussed the results, critically reviewed, and approved the final version of the manuscript.

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