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The perspective of community health nursing in Primary Health Care in Portugal*

A PERSPECTIVA DA ENFERMAGEM COMUNITÁRIA NA ATENÇÃO BÁSICA EM PORTUGAL

LA PERSPECTIVA DE LA ENFERMERÍA COMUNITARIA EN LA ATENCIÓN BÁSICA EN PORTUGAL

Maria Adriana Henriques[1], Elisa Garcia[2], Madalena Bacelar[3]

ABSTRACT

Portugal, in 2005, initiated to reconfigure its health centers, an action referred to as the reform of primary health care, with the objective to improve accessibility, efficiency, quality and the continuity of care, and increase the satisfaction of the population and the professionals. The health center groups were reorganized and new types of units were created. Also, at the same time, the health care continuity process and the national network for integrated continuous care were developed. The nursing interventions in the care provided to individuals, families, groups and communities, in the current reform, are essential for success. The first reports still indicate a few inefficiencies that the current reform proposed to systematically improve, affecting the quality of good practices, users' well being, and workers' satisfaction.

DESCRIPTORS

Community health nursing
Primary Health Care
Community Health Centers

RESUMO

Portugal, em 2005, iniciou uma reconfiguração dos centros de saúde que nomeou como reforma da atenção básica, com os objectivos de melhorar a acessibilidade, a eficiência, a qualidade e a continuidade dos cuidados e aumentar a satisfação dos profissionais e cidadãos. Foram reorganizados os agrupamentos de centros de saúde e criadas novas tipologias de unidades de cuidados. Paralelamente foi desenvolvido o processo de continuidade de cuidados e a rede nacional de cuidados continuados integrados. As intervenções de enfermagem nos cuidados a pessoas, famílias, grupos e comunidades, na atual reforma, são fundamentais para o seu êxito. Os primeiros relatórios apresentam ainda algumas ineficiências que a actual reforma se propõe melhorar de forma sistemática incidindo na qualidade das boas práticas, no bem estar dos usuarios e a satisfação dos profissionais.

DESCRITORES

Enfermagem em saúde comunitária
Atenção Primária à Saúde
Centros Comunitários de Saúde

RESUMEN

En 2005, Portugal inició una reconfiguración de los centros de salud a la que llamó reforma de la atención básica, con los objetivos de mejorar la accesibilidad, eficiencia, calidad y continuidad de los cuidados y aumentar la satisfacción de los profesionales y ciudadanos. Fueron reorganizados los organigramas de centros de salud y se crearon nuevas tipologías de unidades de atención. Paralelamente, fue desarrollado el proceso de continuidad de atención y la red nacional de atención continuada integrada. Las intervenciones de enfermería en la atención a personas, familias, grupos y comunidades, según la actual reforma, son fundamentales para su éxito. Los primeros informes determinan aún algunas ineficiencias que la actual reforma se propone mejorar de forma sistemática, incidiendo en la calidad de las buenas prácticas, en el bienestar de los pacientes y en la satisfacción de los profesionales.

DESCRIPTORES

Enfermería en salud comunitaria
Atención Primaria de Salud
Centros Comunitarios de Salud

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INTRODUCTION

The Alma-Ata declaration, which emerged as a result of the 1st International Conference of 1978, defined primary healthcare (PHC) as crucial to achieving a level of health in which a socially and economically productive life would be granted to everyone. This was the beginning of the *Primary Health Care movement*. Professionals and institutions, governments and civil society organizations, researchers and small organizations decided to address the problems of inequities in healthcare[1]. Since 2005, the reform of primary health care in Portugal has been invigorated.

First Generation Health Centers were created in Portugal in 1971 and have developed through different stages in the last 40 years. At the time of their creation, Portugal presented very unfavorable socioeconomic indicators in the context of Western Europe. In this initial phase, the activities of the Health Centers (HCs) were associated with what was considered to be public health at that time – population vaccine coverage, surveillance of pregnant women and children, school health, and activities of health authorities concerned with epidemiologic control and surveillance.

In this context, community health nursing focused on disease prevention and health promotion within vulnerable groups (mothers, children, youths, and families at risk of poverty). Nursing activities were conducted in teams and were articulated with groups of specialized physicians, pediatrics, gynecologists and public health doctors, as well as integrated in vaccination campaigns and practices of health promotion essentially for women and children[3]. Two styles of practice coexisted: one based on community health, which aimed to promote health and prevent disease, and another, a predominantly curative practice, which tried to respond to the demands of the people at the clinics of the Social-Medical Services and at the Social Security Services providing consultations, treatment and domicile visits to administer medication and nursing treatment. This distinction in healthcare practices perpetuated, from the organizational point of view, until 1982[4].

A major change started to be designed with the creation of the National Health Service in 1979. This service was proposed to be universal and progressively free, and was established in the new Federal Constitution, which fostered hope for better healthcare for everyone and the idea of progress and social justice[3]. In 1983 the HCs assimilated curative healthcare and originated the Integrated HCs, called Second Generation HCs[3]. This process led to the creation of the General Direction of Primary Healthcare and to a better formal rationalization of the healthcare resources. However, despite the change in the organizational structure, the healthcare practice of the first generation HCs persisted throughout the years as a result of administrative and governmental models.

In the decades of the 1980s and 1990s, health policies were strongly influenced by the health promotion movement advocated by the WHO and originating from the Ottawa Charter of 1986 and others which stimulated the development of projects such as *healthy cities* and *health promoting schools*[5].

In 1990, the Law of Health Bases (law No. 48/90 of 24th august) valorized the importance of PHCs in the healthcare system. It was established that the healthcare system must be structured upon PHCs, be situated within the communities and provide intense articulation between the different healthcare levels.

From 1996 to 1999 a goal-driven health strategy was introduced. This strategy identified 27 areas of intervention, ranging from *active life* to *aging*, from youth school health to depression in the elderly, including domains such as access to healthcare services, management of resources and medication, and European cooperation. Goals of 5 to 10 years were defined for these domains and guidance for achievement of this was provided[5].

... despite the change in the organizational structure, the healthcare practice of the first generation HCs persisted throughout the years as a result of administrative and governmental models.

In 1999, the Third Generation HCs emerged based on field experiences and on a philosophy of group practices. These HCs were user and community oriented, had small multi-professional units, and were organized by lists of users from small geographical areas situated in the community. Although they were formally defined, they never actually worked but served as a base for the reform of primary healthcare that started in 2005 and aimed to reorganize the HCs.

Community health nursing, centered on working with families and groups in the community, was strengthened with the Munich Declaration of 2006[6]. This declaration aimed to identify specific actions in order to support the capacity of the nurses to contribute to healthcare and the quality of life of people seeking care. Family health nursing became identified and valorized in the public health and primary healthcare context.

At that time, community health nursing received a legacy that demanded deep changes in the level of preparation of the *family nurses*. These nurses would have to know how to smoothly coordinate and articulate knowledge from different work instruments – originating from public health, clinical practice and primary healthcare - which were developed in different ways, with mismatched times and rhythms[7]. This new perspective demanded the development of a view regarding what public health and

the professional exercise of the community health nurses had been until that time. The outline of this evolution is presented in Figure 1.

In 2003, the Decree-law No. 60/2003, of 1st April, established the constitution of the PHC provision network, maintaining the individual, family and community as the target of the care. It was also in 2003 that a new healthcare strategy, called the National Plan 2004-2010, started to be developed[5]. However, it has been verified that, throughout these years, the hospital network was overvalued and grew oversized. Human resources for primary healthcare continued to be scarce, regarding both the number of physicians and nurses. In 2008, the distribution of workers of the Ministry of Health was only 24% in Primary Healthcare and 76% in the Hospitals[8].

In 2005, the Council of Ministers created the Primary Healthcare Mission, with protocol No. 157/2005, of 12th October, which aimed to run a global project of HC reconfiguration and autonomy, to implement Family Health Centers (FHC), to restructure the Public Health Services, to reorganize the community intervention and homecare teams, and to implement continuing care, mobile units and family support networks. The PHC reform aimed to improve accessibility, increase the satisfaction of the professionals and users, improve the quality and continuity of care and improve the efficiency of the system[9].

In the last 40 years, the economic and social situation in Portugal has undergone a significant improvement[10], which has resulted in health gains, especially in the augmentation of the average life expectancy and the reduction in the infant mortality rate. For the period 2008 to 2010 the average life expectancy for both genders was 79.20 years, being 76.14 for males, and 82.05 for females[11]. In 2008 the infant mortality rate was 3.3 per 1000 live births[12], and was considered one of the lowest rates in the world[13].

Currently, the HCs are a cultural, technical and institutional heritage that must be preserved, however, they also need to be modernized and developed since they continue to be the most efficient and accessible way to promote and preserve the health of the population[14-15]. The complexity of Human health requires a systemic, integrated and continuous approach, performed by multidisciplinary and intersectoral teams that are able to offer care centered on the client and the family in their life context. This care should be organized toward the promotion and protection of health, considering the caregiving partners in the management of acute or chronic diseases within a

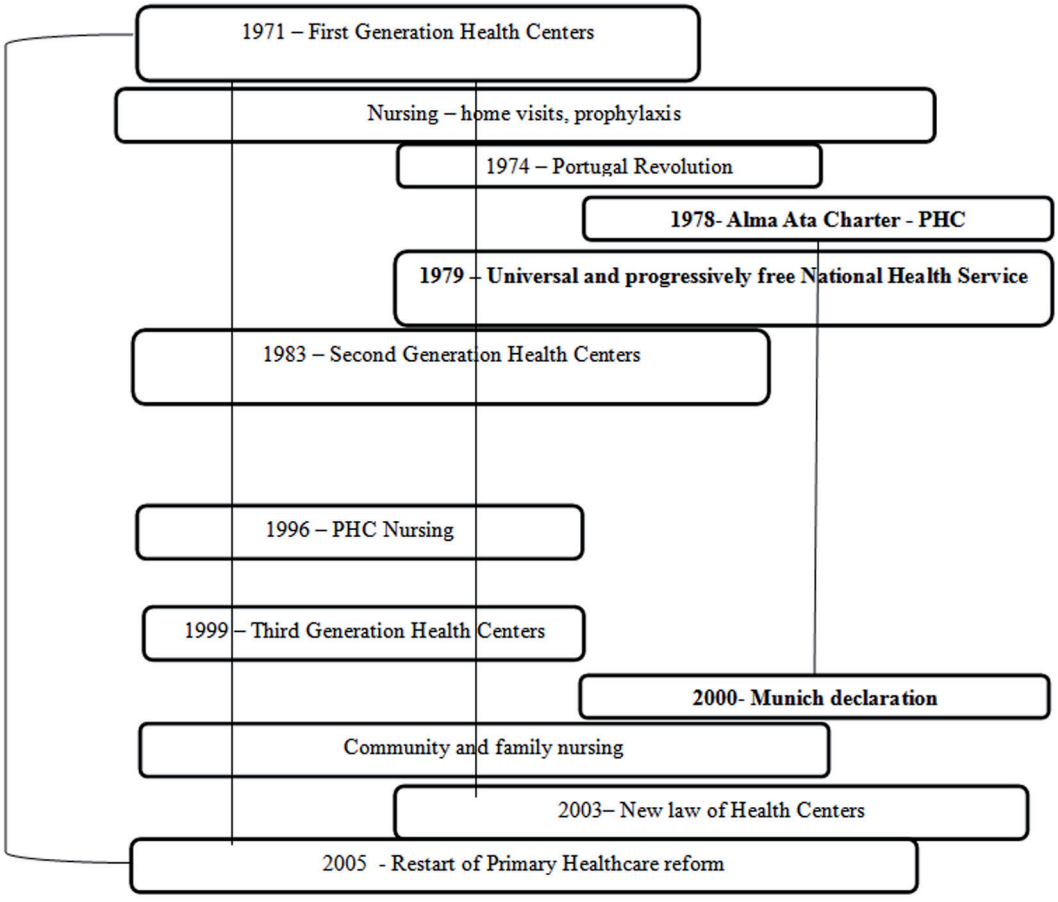

Figure 1 - Evolution of Primary Healthcare in Portugal (1971-2005)

rationale of proximity. Because people are older and more solitary and the families less and less capable of caregiving, the social and healthcare systems have to respond to these people, to their multiple and complex necessities, in order to diminish the inequities in healthcare. Therefore, community nurses must anchor their interventions in a clinical practice based on evidence, reality and knowledge of the context.

The reconfiguration of the HCs led to the creation of multiprofessional teams that act in accordance to their specific missions, that direct their intervention toward the person and the family, as well as Personalized Care Units (PCUs), which target groups with special needs, Community Care Units (CCUs), which intervene in the community, and the Public Health Units (PHUs) which promote actions directed toward the population in general and its physical and social environments, with actions of a populational scope[16-17].

In the current context, there are good examples of integrated and articulated responses in different areas, such as Maternity, with programs of preparation for parenthood and domicile visits for puerperae and newborns; the Infant-Youth Health area, with the promotion of breast feeding and participation in programs of early intervention for children, in the national program of school health, and in the dynamization of youth care spaces; Vaccination, in order to achieve an excellent national coverage rate; implementation of consultations specifically oriented to people at cardiovascular and metabolic risk (hypertensive and diabetic patients); implementation of anti-smoking consultations; constitution of homecare teams for the provision of integrated and continuous social and health care, with a perspective of the involvement of the family/caregiver in the complete care process; the training of volunteers to accompany solitary people; and the use of mobile units as a strategy to reduce the distance between the healthcare services and population[16].

Throughout this period, with the reform of the Public Health Centers, a progressive transition has been witnessed from the centrality of the services to the process of community healthcare, targeted toward families and vulnerable groups. This shift allowed the healthcare interventions, specifically community nursing and public health interventions, to focus on their capacity to promote healthy living.

In addition to the reconfiguration of the functional units, the PHC reform included the creation of Health Centers Clusters (HCC) which aim to provide the current HCs with an organizational setting and support structures that would allow them to provide quality care within a logic of service provision and optimization of flows of information[14]. Each HCC is geographically and functionally related to a reference hospital, with the reference established by an integrated computing system. There is a Clinical Council in which a nurse participates. Currently, the emphasis is on clinical governance, on clinical management of the human resources and on the contractualization as well as the development of the functioning units[17].

Since 2006, the multiprofessional teams were organized in Family Health Centers (FHC) which contracted a basic portfolio of services and adopted a reward system based on productivity, accessibility and the quality of services offered. The process that started with only 10 FHCs developed into 285 that contain 5,656 professionals and cover 3,559,489 users, with an additional gain of 468,381 users that started to have their own family physician, in relation to the pre-FHC situation[18].

Community Care Units (CCUs) started to be implemented later, in 2010 and in April of 2011 there were 95 CCUs[18]. The CCU is a multidisciplinary unit that encompasses healthcare, and psychological and social support, based on geographical and domicile distribution. It aims at identifying and supporting people and families with greater risk, dependency and health vulnerability, especially pregnant women, newborns and people with functional dependency or with diseases that require close and regular monitoring. The provision of these services requires a hierarchy of priorities that considers the magnitude and severity of each of the situations or problems, the necessity of care and the available of resources. The CCUs are coordinated by specialized nurses and generally provide care within the community[9]. Depending on the needs presented by the person or group requiring care, it may be necessary to resort to specialized assistance available in other functional units of the Health Center Cluster. Whenever this is necessary, CCUs can complement the services they provide by asking for the support of professionals (such as psychologists, Social Service technicians, hygienists) from the Shared Care Resources Unit (SCRU).

In the Public Health Centers, public health nurses or community health nurses are part of a multidisciplinary team and undertake the following activities: collaborate in the elaboration of information and plans in the public health domain, collaborate in epidemiologic surveillance, monitor the health levels of the population and diagnose the situation of the population through the systematic collection and analysis of health data, support the elaboration of the local health plan, and communicate health related information to the functional units and the community. Public Health Centers are responsible for proposing interventions that may contribute to a reduction in the identified health problems, as well as reinforce or maintain the health achievements[19].

Independent studies were conducted to evaluate the efficiency and level of satisfaction of the users and the professionals. The results highlight the satisfaction of the users with professionals in the relational and humane components[14]. The nurses identify autonomy, teamwork, satisfaction and professional motivation as factors associated with success. As their major problems, they highlight communication, articulation, the information systems and obstacles to implement domicile care[20].

Professionals who work in the Health System of Portugal are family physicians, specialists in general and family practice, psychologists and social workers, among others. The nurses are generalists and specialists in different nursing areas. In the last five years, the Portuguese schools of nursing have contributed to the development of the specialized formation for post-graduate nursing students, specifically in public and community health and family health nursing.

FINAL CONSIDERATIONS

The challenge of providing universal and quality healthcare, with efficiency and sustainability of the system and rewards for good professional practices, must be embraced by all the professionals who participate in the macro, mezzo or micro level of the health policies. In opposition to the traditional discourse, contemporary discussions of economic, social, cultural and political matters situate quality of life as central. This new discourse proposes a fresh social practice centered on change[21]. From this perspective, the community health nurses focus their intervention according to a health promotion paradigm, in which care is centered on the person, groups, family and community. In accordance with the new paradigm in healthcare, the systematization of nursing care must be interrelated with professional autonomy, autonomy of the patient, and the biological and social needs of the population[22].

It is important to keep in sight the development of the articulation between the PHC reform and the network of integrated and continuous healthcare. The validation of community, family and public health nurses will solidify in the different functional units in which they work, in accordance with national health plans and in partnership with users. Within this partnership, the responsibility of the users for their own health and self-care can be instigated, as well as the sustainable use of the healthcare and social resources. To enable users to assume control of the management of their own health is one of the main challenges of the community health nurse.

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