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The perception of hypertensive elderly patients regarding their health needs

PERCEPÇÃO DE IDOSOS HIPERTENSOS SOBRE SUAS NECESSIDADES DE SAÚDE

PERCEPCIÓN DE ANCIANOS HIPERTENSOS SOBRE SUS NECESIDADES DE SALUD

Maria José Sanches Marin¹, Flávio Henrique da Silva Santana², Maria Yvette Aguiar Dutra Moracvick³

ABSTRACT

Considering the prevalence of arterial hypertension among the elderly, the present study analyzes their perception of health needs, in a qualitative way, from focal groups with elderly users of Family Health Units. Data analysis was performed according to the hermeneutic-dialectical perspective and resulted in three nuclei of meaning: *recognizing the possibility of having access to basic health care together with the desire to consume services of greater complexity and understanding the shortcomings of the State; attachment and welcoming as fundamental elements in the feelings of support and security and autonomy permeated by the tranquility to deal with the disease and the difficulties imposed by conditions inherent to the subjects' life style*. Therefore, it is understood that the Family Health Strategy has been complying with its role in terms of the access to the healthcare system and regarding the professional-user attachment. However, health care continues to be centered on the disease rather than the individual.

DESCRIPTORS

Aged
Hypertension
Health care
Health of the elderly
Family health

RESUMO

Considerando a alta prevalência de hipertensão arterial em idosos, o presente estudo analisa a percepção dos mesmos sobre as suas necessidades de saúde, de forma qualitativa, a partir de grupos focais, com idosos usuários de Unidades de Saúde da Família. No processo de análise dos dados, que segue a perspectiva hermenêutico-dialética, elaboram-se três núcleos de sentido: *O reconhecimento da possibilidade de acesso à atenção básica concomitante ao desejo de consumo de serviços de maior complexidade e a compreensão das fragilidades do Estado; O vínculo e acolhimento como elemento fundamental no sentimento de amparo e segurança e a autonomia permeada pela tranquilidade em lidar com a doença e as dificuldades impostas pelas condições inerentes ao modo de vida dos sujeitos*. Compreende-se, assim, que a Estratégia Saúde da Família vem cumprindo o seu papel no que se refere ao acesso à porta de entrada e do vínculo profissional-usuário. No entanto, o cuidado à saúde continua centrado na doença.

DESCRIPTORES

Idoso
Hipertensão
Atenção à saúde
Saúde do idoso
Saúde da família

RESUMEN

Considerando la alta incidencia de hipertensión arterial en ancianos, este estudio analiza su percepción sobre las necesidades de salud, de forma cualitativa, a partir de grupos focales, con ancianos usuarios de Unidades de Salud de Familia. En análisis de datos, según perspectiva hermenéutico-dialéctica, se elaboran tres núcleos de sentido: *Reconocimiento de la posibilidad de acceso a atención básica concomitante al deseo de consumo de mayor complejidad y la comprensión de las fragilidades del Estado; Vínculo y recepción como elemento fundamental en el sentimiento de amparo y seguridad y Autonomía atravesada por la tranquilidad de lidiar con la enfermedad y las dificultades impuestas por las condiciones inherentes al modo de vida de los sujetos*. Se entiende así que la Estrategia Salud de la Familia viene cumpliendo su papel en el sentido de brindar accesos y del vínculo profesional-usuario. Mientras tanto, el cuidado de salud continúa centrado en la enfermedad.

DESCRIPTORES

Anciano
Hipertensión
Atención a la salud
Salud del anciano
Salud de la familia

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INTRODUCTION

The growth of the elderly Brazilian population has caused deep changes in society. This impact, which will probably be even more extensive in the future, affects the economy, the labor market, family relationships, and the health system. Prospects indicate that the elderly population will account for about 15% of the total Brazilian population in 2020, far above the 4% in 1940. Brazil, in 2015, will be ranked as the sixth country with the largest elderly individuals⁽¹⁾.

Aged individuals have specific physiological, psychological and social frailties, due to the losses that occur throughout life, which make them susceptible to health state alterations, and their problems are marked by their diversity, chronicity and complexity.

In this context of the fast demographic change and vulnerability of the elderly, there is a need to organize healthcare services in new ways, so it is possible to deal with an epidemiological profile that is marked by the predominance of chronic-degenerative diseases, which demand long term care with emphasis on managing risk factors. Among the chronic ailments, cardiovascular diseases are the main cause of death in the elderly, as they may cause impairment, dependence, and autonomy loss, thus accounting for a high economic and social cost. Among the cardiovascular diseases, the most prevalent is Systemic Arterial Hypertension (SAH), which increases progressively with age⁽²⁾.

In countries of the Americas and the Caribbean, chronic diseases cause up to 75% of deaths, of which cardiovascular diseases account for about 30%. In Brazil, cardiovascular diseases account for over 250,000 deaths per year, and SAH is involved in almost half⁽³⁾.

Epidemiologic studies have shown that higher arterial hypertension increases cardiovascular morbidity and mortality, and that by reducing the systolic and/or diastolic pressure levels there is a significant reduction in cardiovascular morbidity and mortality⁽⁴⁾.

In Brazil, the Ministry of Health estimates that 35% of the population over 40 years of age has arterial hypertension (AH), which, in absolute numbers, refers to 17 million individuals with the disease. Among the elderly, the prevalence is 50% of the population, and about 75% of those people seek the national health system (*Sistema Único de Saúde* - SUS) to receive primary care⁽⁵⁾.

SAH is considered the most important modifiable cardiovascular risk factor. However, the lack of appropriate management is associated with complications that often affect the elderly, such as coronary artery disease, cerebrovascular disease, heart failure, and chronic renal insufficiency, besides accounting for 40% of early retirement and work absenteeism cases⁽⁶⁾.

SAH is considered the most important modifiable cardiovascular risk factor. However, the lack of appropriate management is associated with complications that often affect the elderly...

In this context, the healthcare for elderly individuals with hypertension should be considered a priority by healthcare services, particularly in primary care, aiming at an appropriate management. It is emphasized that care for the elderly implies to offer services with a structure that permits appropriate accessibility and welcoming, respecting the limitation and relevant proportions of the elderly⁽¹⁾.

Literature shows that few studies address elderly care in primary healthcare, particularly in the Family Health Strategy, because it is a modality that only recently has become a priority of public policies⁽⁷⁾.

The consideration of how the elderly should be cared for at the primary healthcare network recalls the concept of health needs, which has been addressed as a way of expanding the view healthcare for people, families, and the community with the purpose to overcome the care model centered on the biological aspects and cure of diseases.

In this perspective, it is highlighted that, due to the range of the health concept proposed in the institutionalization of the SUS (national health system), the activities that respond to the health needs should focus not only on the disease, but on the determinants of the health/disease process⁽⁸⁾. They do, however, add that in the operational field the healthcare projects have associated the health needs to the consumption of a service, usually a medical appointment.

Based on the expanded view of the health needs and aiming at a better understanding of its meaning, health needs are classified into four broad groups. First, they are the **good life conditions**, because one's lifestyle translates into different needs, and the external factors respond for determining the health/disease process. Then, there are the aspects regarding **accessibility to technologies** that improve and prolong life; in this case, the value determined for each technology should be defined by each person's need, in each moment. The other aspects explored by the author are related to **forming effective attachments** between the user and the health system team or professional; this attachment should be understood, at this time, as a continuous trust relationship with the healthcare professional. The next domain about health needs is associated with the growing level of **autonomy** that each individual has in their way of living, which involves more than information and education⁽⁹⁾.

The taxonomy of health needs has the role of helping health workers/teams/services/network to listen better to the people that seek *health care*, making their needs the center of their intervention and practices⁽⁸⁾. In this sense, the need represents the problem that needs solving.

It is also admitted that reflecting about health needs and how work is guided in this field requires an understanding of how human needs are created and fulfilled socially and the relationship between health work and the system of needs⁽¹⁰⁾.

Therefore, we believe it is important to know the perception that elderly hypertensive patients have about their health needs, with a view to establish intervention strategies that meet their own expectations. Thus, we propose to analyze the perception that elderly hypertensive individuals have about their health needs.

METHOD

This qualitative study was performed with elderly individuals with arterial hypertension, living in areas covered by the Family Health Strategy (FHS) of Marília. The city of Marília is located in the mid-west region of the state of São Paulo, and has a population of approximately 220,000 people. Today, the city counts with 31 Family Health Units (FHU), which, in the area they cover, are the entrance door to the health system. Each unit deals with the health risks and ailments that occur in its area.

Generally, the FHUs in Marília meet the minimum requirements necessary for their implementation, in compliance with the Ministry of Health, regarding its physical structure, minimum composition of the team, and the development of basic national programs, organizing the teamwork centered on users' needs, which are discussed in weekly meetings, and performing monthly meetings with the community. The appointment schedules are planned according to spontaneous demand, with local appointments with the physician, dentist and nurse, home visits to impaired users, and activity groups. These units are established in areas where the population has more socio-economic needs, caring for approximately 96,000 people, which is about 44% of the Marília population.

For data collection, a draw was performed to select four FHUs, each from one region of Marília, as follows: North – FHU Vila Nova; South – FHU Santa Augusta, East – FHU Aeroporto (airport), and West – FHU Jardim Marília.

Data were collected from focal groups, which reveal the subjectivity of the subjects, who express their experiences in the field of study through oral reports and group discussions. Using this technique, it is possible to gather, in a short period of time, a group of people to generate, through interaction, a volume of material that provides significant content.

The focal group is a technique that permits to collect qualitative data from a certain group that has some common trait, by establishing, among other aspects, uniformity by theme, interest or phenomenon to be discussed. The group discusses a given theme based on triggering questions, addressing several aspects about it, and the data are collected from that discussion⁽¹¹⁾.

In compliance with the instructions to perform the focal group, each session counted with one coordinator/facilitator experienced in the technique, who conducted the group activities by making triggering questions for the discussions, maintaining the focus on the study objective, and bringing the group back to the question in case there was any dispersion. The focal group also counted with a moderator that recorded the sessions and made sure the participants were comfortable. In every unit, efforts were made to provide a comfortable place, free from interferences.

The following guiding questions were used in the focal group: What does having arterial hypertension mean to you? What do you consider necessary to take appropriate care of your health? What do you think the healthcare service should provide for you to take better care of your health? The participants' reports were recorded using a digital recorder, and were later transcribed.

To select the participants, each FHU was contacted and the Community Health Agent (CHA) was asked to point out two elderly hypertensive patients who had the necessary physical and psychological conditions to participate in the focal group, which had been previously scheduled. This way, one focal group was performed in each of the selected units, counting with the participation of eight to ten elderly hypertensive individuals per group.

Data analysis was founded on the hermeneutic-dialectic method, guided by the principles of *the method for the interpretation of meanings*, which aim at the interpretation of the contexts, actions, reasons and logic of the statements, correlating the data to the group of interrelations and conjectures, among other analytical bodies⁽¹²⁾.

From this perspective, a comprehensive of the transcripts from the focal groups was performed with elderly hypertensive individuals to identify the regularities and unique experiences, through the meanings subjacent to the ideas described in the statements. Finally, an interpretative synthesis was created, anchored on the confrontation of points of view and on the expressions of the actors' experiences. This synthesis incorporated, in a critical way, the interpretation of the authors about the interpretations produced by the actors (hypertensive elderly individuals), seeking to bring more clarity to the perception regarding their health needs.

This study was approved by the Municipal Health Department and the Research Ethics Committee in Research on Human Beings of the Marília Faculty of Medicine, protocol number 565/09. All the participants, after having been informed about the purpose of the study, signed a Free and Informed Consent Form.

RESULTS

By analyzing the set of narratives by the elderly individuals with arterial hypertension who participated in the

focal group about their health needs, considering accessibility, good life conditions, attachment and autonomy, it was possible to elaborate the following nucleus of meaning: *Recognizing the accessibility to primary healthcare while wanting to obtain services of greater complexity and the understanding that the state has weaknesses; Attachment and welcoming as essential elements for feeling support and security in face of the health needs and The autonomy permeated by the tranquility of dealing with the disease, in spite of the difficulties imposed by the internal/external conditions inherent to the subjects' lifestyle and their lack of knowledge.*

DISCUSSION

Recognizing the accessibility to primary healthcare while wanting to obtain services of greater complexity and the understanding that the state has weaknesses

Regarding accessibility, the interviewed users do not complain about primary healthcare, supposedly because they believe that this service is satisfactory, as observed in the following statements.

... sometimes the doctor measures my blood pressure twice a day, I don't have any complaints about the health center, they are great, I love everyone here, I have no complaints (P1, fem., 69).

...I have nothing to say, the girls here at the health center are very kind, they take care of us every time we need... (P2, fem. 62).

However, accessibility, as a right guaranteed by the Brazilian constitution, is not limited to entering the health system, because the guidelines also point to the universality and equity of that accessibility, which must occur under the tutelage of the state, with a view to guarantee the comprehensiveness of care.

Although the FHS has undoubtedly contributed with the accessibility of the population, particularly those with more socio-economic needs, on the other side, it is observed that the axes related to the equity of accessibility to all the technology that is available to improve the individuals' life and health conditions remains an utopia, as it is segmented and disconnected from the public health system and the system's organizational chain as a whole⁽¹³⁾.

You even feel sorry, you wait in line for six months to get an ultrasound by the SUS (national health system), sometimes it takes a year and the person dies (P3, fem., 65).

In this regard, it was considered that the FHS must be incorporated to a network of more complex services, because, working alone, it is unable to respond to the users' health needs⁽¹⁴⁾. It is also highlighted that it is a proposal of a health system that works in a circle, eliminating the barriers between the different levels of care, connected by strategies of management, funding, and informa-

tion, functionally integrated and guided by an agile and flexible system, capable of making decisions and sharing responsibilities⁽¹⁵⁾.

In view of the incapacity of the public health system to offer services to meet the needs of the population, it becomes evident that there is a desire to consume private services, as a form to obtain security regarding their health needs.

I think, like, that seniors must have a health plan, because you're doomed if you don't (...) you should reach an old age with at least some security, because that (security) is what people who buy a health plan have... (P4, fem., 71).

The situation of lacking support in terms of having their health needs met appears to be more intense in the elderly, because during life they contributed with state taxes, and, when they reach a vulnerable phase of their health condition, they suffer social and social discrimination and have no guarantee of a fair survival.

...if he wanted to receive good care in the health area then he has to pay for a health plan that is too expensive at his age, because he was already 63 years old, and for me too so I think the government should see these things and think more about the population and the aged people (...) the aged people, right, they work so much in life and he should have a peaceful old age. (P5, fem., 62)

Understanding that health needs are historical and socially constructed and consist of a pre-requisite for autonomous and emancipating lives, it is indispensable that the state guarantees it as a social right⁽¹⁶⁾.

Recalling the subjects' statements, it is observed that accessibility is compromised in its different dimensions⁽¹⁷⁾. From the economic point of view, there is an inequitable power of purchase among users and a clear supply/demand unbalance. Regarding the technical dimension, the organization of a hierarchized organization of services should be one of the items in the planning to promote the accessibility of the population to different healthcare levels. In this perspective, healthcare networks, due to their different roles and profiles, should establish mechanisms for continuous healthcare across the different levels of the healthcare system in the search for the comprehensiveness of care⁽¹⁷⁾.

Although the elderly are informed about the duty of the state and their right as citizens, in the political dimension of the accessibility to healthcare services, a passive knowledge prevails over a citizen awareness on behalf of the community and it becomes evident there is a privatization logic that the neoliberal model imposes over healthcare services.

Under a symbolic view, the subjects' statements reveal that, on the one hand the FHS is a place of symbolic interaction that permits establishing horizontal relationships between users and the health team, as well as establish-

ing attachment; while, on the other hand, there is a prevalent desire to consume higher complexity technologies. In this dimension of accessibility, it is observed that they consider that an ideal care is medicalized and centered on the complaint, often moving against making changes in the healthcare model with emphasis on health promotion, despite the fact that the care and demand are also part of the FHS agenda.

For me, this health center is good, thank God it is good, whatever I need, what I feel, like (...), they go and give me the medication, for me, it's working (P6, male, 70).

...so, if you need a referral we go there (...) I need a faster referral and I always need some exams and my referrals come fast (P7, fem., 60).

This acceptance that conforms to the historical and cultural roots and is socially constructed by the subjects and social groups also permeated the practices developed by healthcare professionals in the daily health service work, because they are based on the system of current beliefs regarding the health/disease process, that is founded on the centered medical paradigm⁽¹⁴⁾. We alert, however, about the need of broader listening, because the conditions that truly need care go by implicit in the stated claim⁽⁹⁾.

Attachment and welcoming as fundamental elements in the feelings of support and security in the view of health needs

Aiming to make changes in the healthcare model, The Ministry of Health proposes the FHS and defines as its guideline *to establish attachments and create commitment and responsibility bonds between the community and healthcare professionals*⁽¹⁸⁾.

According to the subjects' statements, there is an approximation between users and healthcare workers, involving affectivity, help, respect, trust, and shared responsibility. In this view, it is possible to infer the occurrence of attachment and that it is capable of improving the efficacy of health activities and favor the participation and involvement of subjects in the healthcare.

I am also taken good care of here, because I live only one block away, so I say: it's going to be 30 years that I have this house, and I am staying here, I'm dying here (...) the day I can't make it to the health center, I know the doctors and nurses will go there, because they follow up (P8, fem., 70).

When they realize we don't come here to the center they always go to my house and say Mrs. L how are you, are you taking your medication, they ask us to always keep track (...) we arrive here and they are always ready... (P9, fem., 75)

In this sense, despite the contributions of the FHS for an effective change in the healthcare model not having been as expected, it is observed there have been effective changes in the relationships, because the profession-

als now understand users as a whole, in their family and social context and in different daily life situations, different from the other healthcare models that coexist in the health system.

Therefore, there is an improvement of the sensitivity of the others' suffering and the feeling of responsibility for life, which permits an intervention that is committed with the subject who needs to be cared for.

Because attachment is inherent to good human relationships, in healthcare, particularly to elderly individuals who usually demand long-term care, *broader listening* and respect towards their needs must permeate the user/professional relationships. The contrary, according to the report of an elderly participant, it can reflect on how one deals with the health conditions, due to the lack of trust and devaluation of the conduct that was adopted.

...many times, you arrive at the doctor and try to explain your situation. The doctor says: take this and doesn't really care (...) I'm going to buy a liter of 51 (a Brazilian alcoholic beverage) and leave it here and take one dose, in the morning I'll take a small dose, midday I'll take another, and in the afternoon I'll take another and who knows I'll get better, because these medications are not solving it, I got my medications at the people's pharmacy, it looked like it had flour in it. (P2, fem. 62)

Aiming to understand comprehensive care from the users' view, it was found that their main indignation regarding the care they received at the healthcare services refers to the relationship between who needs care and who offers the care, suggesting that the professional/user relationship is a fundamental element in the healthcare context, often overcoming the needs concerning service management⁽¹⁹⁾.

According to the SUS (national health system) propositions and guidelines, attachment also refers to an axis that would respond for the changes in the model, which, in the subjects' statements, appears as the perspective of the disease such as controlling arterial blood pressure, receiving medications and being referred to higher complexity services.

Therefore, although the attachment established between users and FHS professionals is effective, it appears to emphasize on dealing with the diseases, as there is little evidence showing a path towards the logic of health promotion, particularly if it is considered that, regarding the hypertensive elderly users, health promotion actions are needed because they are in a very vulnerable phase of life.

Autonomy permeated by the tranquility of dealing with the disease, in spite of the difficulties imposed by the internal/external conditions inherent to the subjects' lifestyle and their lack of knowledge.

Regarding elderly individuals with a chronic disease, such as arterial hypertension, it is important to consider

the constant need to manage their life conditions and the need to change habits and lifestyles, with a view to maintain their quality of life, and their desired development of autonomy for self-care.

When it is considered that autonomy, in its broader concept, *refers to the subjects' capacity to assign a direction to their actions, on their own, and independently*⁽²⁰⁾, in the construction of a model in harmony with the broader concept of health, it is understood that it allows subjects to lead their own lives in a sustainable and permanent way.

For some of the elderly subjects, having arterial hypertension is seen as a condition that does not cause suffering and distress, because they consciously incorporated the care to their daily life.

I do my work I take my medications as prescribed; I've been aware of this blood pressure for 20 years... (P10, fem., 61)

After I changed my eating habits it went to 12 by 8, 12 by 7, thank God I managed to loose 22 kilos, because I had to loose a few kilos (P9, fem., 75).

I don't push the limits, in fact I don't have dinner at night, I just have some milk, a salt water cracker, and that's it, sometimes some tea and that's it, I take my medication every day, I love fishing, that is 15, 20 days on the shore fishing, that is what entertains me a lot, after I started doing that I improved 90% (P3, fem., 65).

It is understood that autonomy, besides being the patient's ability to know and decide about the treatment, is the effect that their health state has on their life. The elderly subjects' statements evidences that controlling their health state allows them to have a healthy life free from dependences.

Based on these reflections, it is understood that the elderly have a need for a healthcare founded on comprehensiveness and health promotion, and the professional responsible for caring for them should be able to welcome them, besides establishing a relationship of trust and understanding, so that the elderly individual is able to share their worries and anxieties, which often translate into their real health need⁽²¹⁾.

Although the elderly express the possibility of leading an autonomous and peaceful life, they also state difficulties to deal with daily situations that interfere on their health needs.

...it is our nature, right, sometimes I get a bit angry because me get things mixed up (...) it goes up for any little reason if everything is fine, or if it isn't, someone ill in the family... (P11, fem., 63).

...inside my house there is already too much exercising (...) the housework (...) to do even more like walking and stuff like that (P12, fem., 54).

If I eat, I gain weight, if I don't eat I gain weight, so... (P13, fem., 56)

You go to a barbeque and you won't eat... (P12, fem., 54)

The psychological and social tensions can accelerate the deteriorations associated to the process of aging. Therefore, the personal skill of getting involved and finding a meaning to live affects the biological and health changes that occur in old age⁽²²⁾ and, in this regard, hypertension often represents a life context, in view of the fact that the elderly must be encouraged and supported to deal with the situation.

In each person, health information and education are inherent to the process of developing autonomy, and affect the subjects' possibility to reconstruct their life meanings. In addition, this resignification would have an effective weight on their lifestyle, including the search for fulfilling their needs⁽⁹⁾.

Considering health education as a construct of the subjects' autonomy, it is worth emphasizing that this intervention has not been completely explored by the FHS, as the elderly hypertensive individuals also show they lack knowledge regarding the care that should be implicit in the service.

Why does our blood pressure rise, I want to know about that? (...) Doctors say we can't eat beef, pork, right... Why can't we eat beef? (P12, fem., 54).

Just one question, is there any relationship between diabetes and blood pressure, do they affect or cause each other, does diabetes make the blood pressure go up, does high blood pressure make diabetes go up too, do these problems have any relationship or not? (P6, masc., 70).

In face of these difficulties, we stress that there is a need for places to solve these doubts so individuals can achieve the ideal peaceful lifestyle, as it occurs with the elderly that have become aware of the necessary care and are able to maintain their health and prolong their life in a healthy way.

CONCLUSION

In the attempt to understand the health needs of elderly hypertensive patients, from the perspective of a broader health concept and the current health policy, its it confirmed that this complex issue poses challenges to healthcare workers and administrators, as well as to the general population.

Regarding accessibility, although the elderly subjects reported having easy access to primary healthcare, they are still far from receiving care of higher complexity that they are entitled and which are often indispensable for a healthy and autonomous life.

Furthermore, the elderly subjects' perception move towards directions that value the role of relationships, at-

tachment and welcoming emphasized by the FHS, sometimes wanting access to high complexity technologies. In addition, for the elderly, attachment consists in security in healthcare, but within the diseases-centered logic because their major requirement are medications and appointments with specialists and there is no evidence that any other form of care, aiming at health promotion, is being provided.

When the elderly show autonomy to manage health conditions, despite having arterial hypertension, they are able to lead a peaceful life while having difficulties to

change some internal and external conditions inherent to their lifestyle, besides a lack of knowledge regarding essential conditions for managing the disease.

In view of this context, it is understood that the Family Health Strategy has met its role in the sense of providing access to the entrance door to the professional/user attachment. However, healthcare continues to be centered on the disease, considering that the population of elderly hypertensive patients should be involved in actions that improve their quality of life, especially educational activities.

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