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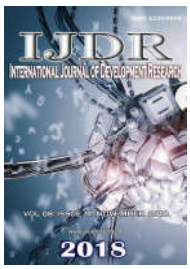

ORIGINAL RESEARCH ARTICLE OPEN ACCESS

# ASSESSMENT OF QUALITY OF HEALTH CARE IN THE FAMILY HEALTH STRATEGY: A PERMANENT CHALLENGE

**[1]Sandra Cristina Souza, [2]Sônia Maria Oliveira de Andrade, [2]Valdir Aragão do Nascimento, [3]Cássia Barbosa Reis, [4]Leandro Júnior de Lima, [5]Gilberto Gonçalves Facco, [2]Igor Domingos de Souza, [2]Fernanda Guerreiro de Paula, Laynara Soares Vilagra and [1]Felipe Zampieri Vieira Batista**

[1]Graduate Program in Family Health, Federal University of Mato Grosso do Sul, 79070–900, Campo Grande, MS, Brazil
[2]Graduate Program in Health and Development in the Mid-West Region, Federal University of Mato Grosso do Sul, 79070–900, Campo Grande, MS, Brazil
[3]State University of Mato Grosso do Sul, Nursing Course, Dourados, Brazil
[4]Graduate Program in Infectious and Parasitic Diseases, Federal University of Mato Grosso do Sul, 79070–900, Campo Grande, MS, Brazil
[5]University for the Development of the Pantanal, UNIDERP, Mato Grosso do Sul, 79003010 – Campo Grande, MS, Brazil

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**ABSTRACT**

The aim of this manuscript was to evaluate the quality of health care offered by the Family Health Strategy, from a professional perspective. It is an evaluative study carried out in the city of Campo Grande / MS, Brazil. For the accomplishment of this study was used a validated instrument widely used in Brazil and in other countries, called PCATOOL. This instrument was applied to professionals of higher level acting in the teams of health of the Brazilian family. The research was developed from March to September of 2017 in 4 basic health units of the family (UBSF), being selected by lot, totaling 40 professionals. The result of the research allowed to obtain the perception of the presence of the attributes of the basic attention in the Family Health Strategy, by the professionals working in these health units. The results obtained in this study were tabulated, evaluated and all the scores for the attributes of basic care were defined. The information indicated that for most professionals there was a low score in the attributes related to basic care, inferring in the lack of accessibility, completeness, coordination of care, family and community orientation. On the other hand, only the longitudinality attribute was well evaluated by professionals.

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## INTRODUCTION

The Family Health Strategy (FHS) aims at the reversal of the care model of the time, and the family becomes the object of health care in the environment in which it lives, favoring an expanded understanding of the health / disease process, replacing the traditional health sector, which has always understood the individual in an isolated way, defined as "producer of procedures" (FRANCO; MERHY, 2003). The question that needs to be answered is whether the attention currently offered by the family health teams respond to the perspective of this new assistance profile, as recommended in the ESF and how is actually experienced in the day to day assistance by the teams and their difficulties in relation to this profile. In recent years there has been a great expansion in the number of family health teams, especially in the last decade with the strong support of the Brazilian Ministry of Health,

***Corresponding author: Valdir Aragão do Nascimento,**
Post-graduate Program in Health and Development in the Mid West Region, Federal University of Mato Grosso do Sul, 79070–900, Cam, Brazil

since the FHT is considered a priority in the structuring of basic care and the preferential entry point of the Universal Health System (*Sistema Único de Saúde*, SUS) (MALTA*et al.,*2016). The accessibility, geographical location of the health unit, the hours and days are some of the important elements for the basic attention to be recognized as a gateway to health services in the SUS. Investments in basic care have brought many results in several countries and also in Brazil, such as reduction in infant mortality rate, fewer potentially preventable hospital admissions, greater equity, more access and continuity of care and less financial cost (MALTA *et al.,* 2016). Due to fact that the municipality of Campo Grande, in the State of Mato Grosso do Sul in Brazil has provided basic health units in its territory since 1998 and currently has a coverage of 41% of this model of care in which it has an exponential increase as perspective, it becomes It is necessary to evaluate this process of health care offered by the Family Health Strategy teams from a professional perspective. Taking into account that the importance of the development of health actions within health teams, the current study seeks to study the knowledge and expertise of professionals working in family health strategy, directly reflecting the quality of care perceived by users of services in basic care, impacting on the health and disease conditions of the population. Thus, the perception of professionals and the impact of these professionals' performance, as well as the systematized knowledge of the quality of services, is a source of planning and implementation for the management of health services in Brazil. In 1920, Dawson's text, a treatise on the organization of the health services system, was disseminated in which three main levels of services were distinguished: primary health centers, secondary health centers, and school hospitals. Thus, this formulation was the basis for the concept of regionalization of health services (STARFIELD, 2002).

In 1977, the World Health Organization (WHO) established that the attainment by all citizens of the world of a level of health that would allow them a socially and economically productive life was necessary. From this statement began a series of activities with great impact on the thinking about Primary Health Care in the world (STARFIELD, 2002). The principles of Primary Health Care (PHC), according to Starfield (2002), were announced at the Alma Ata Conference (1978); and then a concept was defined on Primary Health Care and its fundamental components. The term PHC expresses the understanding of non-specialized ambulatory care, offered through health units of a system, comprising the development of several clinical activities of low technological density and public health activities. Although the concept of PHC was created to be applied in all countries; and even if it emphasizes proximity to people, it is noted that there are countries with health systems based on technology, expertise, hospital supremacy and the curriculum of medical schools that are under the control of specialists (GÉRVAS *et al.,* 2007). However, not all countries have organized their health systems around a strong primary care base, but have reorganized their health services to consolidate aspects of the primary health care service. We can cite as an example the new "family doctors" in Cuba, who live in the community where they work and are agents of change (GÉRVAS *et al.,* 2007).

A comparative study among 12 different western and industrialized nations indicates that countries with a stronger orientation towards primary care have a greater and better supply of health services and actions at lower costs (STARFIELD, 1994).The services are divided into primary care that is recognized as the gateway to health services, comprising the Basic Health Units (BHU) and Basic Family Health Units (BHUH) of medium and high complexity and composed of regionalized services located in emergencies, specialty outpatient clinics and hospital admissions. High complexity is considered a set of procedures that in the context of the SUS involves high technology and cost, whose objective is to provide the population with access to qualified services, integrating them with other levels of care. Medium complexity can be understood as a set of outpatient and hospital actions, characterized by medical specialization, diagnostic and therapeutic procedures and technological densification (BRASIL, 2012). Acriaçãodo SU Spodeser consider adauma“cartafundadora”deumanovaordemsocialnoâmbitodasaú de,baseadanosprincípiosdauniversalidadeeigualdadeorganizados sobasdiretrizesdadescentralização, atendimento integrale participação da comunidade (MENICUCCI, 2009). The predominance of SUS and its impact on the Brazilian population is substantial, that is, the public system has the largest number of health facilities and is responsible for most procedures and coverage of three quarters of the Brazilian population. The organization of care has been a focus of interest since the implementation of the SUS, with the challenge of replacing the hospital-centered model, and in fact providing universal access, particularly to promotion and prevention actions, preserving the principles of universality and integrality. This led to the adoption of more effective measures to make the model change possible, starting in 1994 with the creation of the Community Health Agents Program (PACS) and after the Family Health Program (MENICUCCI, 2009).

**The Family Health Strategy in Brazil:** In Brazil, after the creation of the Unified Health System (SUS), there was a strengthening of Primary Health Care (PHC) focused on actions to promote, maintain and improve health. With the installation and organization of APS, the Ministry of Health (MS) established a health care reordering model in accordance with SUS principles, called the Family Health Program (PSF), which prioritizes health care actions for individuals, families and community, in a continuous and integral way (LIMA *et al.,* 2016). In fact, the Family Health Program (FHS) was implemented in Brazil by the Ministry of Health in 1994, and is currently called the "Family Health Strategy", because it is not only a "program" in which care predominates emergency (BRAZIL, 2011). In addition, in Brazil, the origin of the FHP dates back to the creation of the Community Health Agents Program (PACS) in 1991 as part of the health sector reform process since the Constitution, with the objective of increasing accessibility to the health system and increasing the actions of prevention and health promotion. In 1994, the Ministry of Health started the PSF as a national primary care policy, and in December 1997, Ministerial Order 1886 established the norms and guidelines of the PACS and PSF (ROSA; LABATE, 2005). In this way, the family becomes the object of attention in the environment in which it is included and in which it lives, providing a broader understanding of the health /disease process. The program includes actions to promote health, prevention, recovery, rehabilitation of diseases and more frequent injuries (SANTANA; CARMAGNANI, 2001).

With the expansion of the Family Health Program, which was consolidated as a priority strategy for the reorganization of Basic Health Care in Brazil, the government issued Ordinance

No. 648 of March 28, 2006, which reaffirms action of the PSF as a priority strategy of the Ministry of Health to reorganize Basic Health Care, one of its foundations being to provide universal and continuous access to quality health services, reinforcing the basic principles of SUS. (BRASIL, 2006). In 2011, Administrative Order No. 2,488 / 2011 revoked GM Ordinance No. 648/2006 and established the revision of guidelines and standards for the organization of Primary Care through the National Primary Care Policy (PNAB) for the Family Health Strategy (ESF) and for the Program of Community Health Agents (PACS) (BRAZIL, 2011). The ESF team is made up of different professionals, having as minimum team the doctor, nurse, technician or nursing assistant and the community health agent, and can be grown up from other professionals that are necessary to the municipalities according to reality and the need local (LIMA *et al*., 2016). Ordinance No. 2,436, published on September 21, 2002, established the revision of guidelines for the organization of Primary Care in the scope of the SUS and Family Health Strategy, recognized as the new National Policy for Primary Care (PNAB),(BRASIL, 2017). Ordinance No. 2436 (BRAZIL, 2017), continues to establish a minimum team in the ESF, being a physician, nurse, auxiliary and / or nursing technician and community health agent, and may be added the agent to combat endemics, as well as professionals oral health and other professionals according to the local need. Each team can be responsible for a population of 2000 to 3500 individuals, according to the area's vulnerability.

The family health team has health responsibility within its area of coverage in relation to promotion, prevention, recovery and other actions in the community including home visits by all staff members (PEREIRA; BARCELLOS, 2006). Maintaining the guidelines and principles of SUS as well as the favorable impact on the health conditions of the population served should be the basic priorities of the FHS. It is essential that the team work with a view to knowing its area of extension by expanding the link with the community, quality and access to services provided, as well as strategies and interventions that triggered improvements in the health of the population (LIMA *et al.*, 2016). According to the same source cited above, it is a fact that, over the last few years, the FHT has contributed significantly to the improvement of health indicators in Brazil, altering the morbidity and mortality profile of the population, as well as reducing unnecessary hospitalizations. Thus, the evaluation of the quality of care provided by the FHI is fundamental, since it makes possible new investments in improving the quality of services offered within each health territory, new management and care forms, more accessible, resolutive and humanized actions for users.

**Family health assessment**

Over time, as an increase in ESF coverage, some studies and evaluations were necessary to know the perception of professionals working in FHT, as well as the population assisted by these professionals. At this juncture, the professional and the effectiveness of the actions are important parts of this evaluation. The quality of performance from the perspective of FHS professionals is not regularly evaluated and actions and services may be being developed inadequately or insufficiently**.** (SILVA; BAITELO; FRACOLLI, 2015). Evaluative capacity is useful in the various sectors of society, and in the health area it is necessary to develop evaluative capacity means to promote the competence of the actors to conduct and use evaluation, ensuring viability through an organizational context. In fact, using an evaluation are desirable effects in an intervention. However, it is necessary to recognize that the potentialities present in the evaluative study go through the qualification of the evaluated object, the empowerment of the groups involved, and the generation of subsidies for the continuous theoretical / practical improvement.(HARTZ, *et.al.*,2014). The existence of problems in the relationship and among health teams has already led to the realization of some studies that pointed out that the work of these professionals involved in the FHS maintains the characteristic of compartmentalization, without collective planning that adapts the activities to the needs of the population in the area of comprehensiveness. In addition, reports on the internal relationship of the health team also reveal the existence of collective responsibility, making it difficult for the professionals to establish themselves and consequent linkage as a service and population, and it is up to managers to implement policies that ensure health workers in the FHT and lead to the long wait of overcoming the high turnover of these professionals (COTTA *et al.,* 2006). Another problem is the physician's bond is his insertion of a four-hour work day, resulting in a deficit in the integration of the doctor, staff and community (STRALEN *et al.,* 2008). The health of individuals and groups is taken as an object of work, but the family is still treated following the biological model, which has culminated in the development of focal and fragmented attention, revealing the need to broaden their understanding, the diagnosis of their physical, psychological, social, economic and cultural needs. (SHIMIZU; ROSALES, 2009). In Brazil, as the Family Health Strategy was defined as a center for reorganization of the health care model of the Unified Health System, assessments are necessary to identify critical problems and establish strategies for their resolution. In this sense, one of the instruments used for the evaluation and already validated in Brazil is the Primary Care Assessment Tool-PCA Tool, which allows, through home interviews and/or health services to identify aspects of structure and process of services that require reaffirmation or reformulation in the quest for quality for both planning and execution of actions of PHC and ESF (BRASIL, 2010). PCATool presents in Brazil versions intended for children (PCATOOL version children), adults over 18 years (PCATooL adult version) and intended for health professionals, coordinators and / or managers (PCATooL professional version). Created by Starfield & cols. In the Johns Hopkins Primary Care Policy Center, PCATool measures the presence and extent of the 4 essential attributes and 3 derivatives of APS (BRASIL, 2010). The identification of the attributes of Primary Health Care mentioned allows to verify the association between these attributes and the results, that is, the effectiveness of health care of the population. Including health professionals in the process of evaluating health services means having the view of who is in the service or of a program and who exercises care management, experiencing the realities and difficulties of health services and the Brazilian territory (LIMA *et al*., 2016).

**Conclusion**

The family health strategy emerges as a new model of care with a differentiated focus, aimed at a change in the knowledge and do within the FHS. It is concluded that evaluating the work process in family health teams is necessary as a need to identify the convergent and divergent points with the one recommended in health care policy, in

order to achieve the goal of expanding and implementing in terms of public health in Brazil.

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