Epidemiological profile of users in the area of influence of a family health team

Perfil epidemiológico dos usuários da área de influência de uma equipe de saúde da família

Perfil epidemiológico de los usuarios del área de influencia de un equipo de salud de la familia

RESUMO

Objetivos: Investigar o perfil epidemiológico de uma população descoberta por Equipe de Saúde da Família, e entender como é a relação dessa população com o serviço de saúde. Métodos: estudo realizado na Unidade de Saúde da Família Bancários Integrada em João Pessoa (PB), através da aplicação de questionário a treze pacientes que residiam na área descoberta do território. Resultados: A maioria dos participantes foi do gênero feminino, tinha algum acesso a serviço de saúde particular e relatou conhecer o conceito de área descoberta, mas não se sentiu prejudicado por morar em território descoberto. Contudo convergiram em achar que deveria haver cobertura no território. Conclusão: Os participantes conhecem o conceito de área descoberta, acham importante serem incluídos na área de cobertura da equipe, mas não se sentem prejudicados.

DESCRITORES: Atenção Primária à Saúde; Território; Estratégia de Saúde da Família.

ABSTRACT

Objectives: To investigate the epidemiological profile of a population discovered by the Family Health Team, and to understand the relationship between this population and the health service. Methods: study carried out at the Integrated Banking Family Health Unit in João Pessoa (PB), through the application of a questionnaire to thirteen patients who lived in the uncovered area of the territory. Results: most participants were female, had some access to a private health service and reported knowing the concept of an uncovered area, but not feeling harmed by living in an uncovered territory. However, they converged in thinking that there should be coverage in the territory. Conclusion: the participants know the concept of an uncovered area, they think it is important to be included in the team's coverage area, but they do not feel disadvantaged.

DESCRIPTORS: primary health care; Territory; Family Health Strategy.

RESUMEN

Objetivos: investigar el perfil epidemiológico de una población descubierta por el Equipo de Salud de la Familia y comprender la relación entre esa población y el servicio de salud. Métodos: estudio realizado en la Unidad de Salud de la Familia Bancaria Integrada de João Pessoa (PB), mediante la aplicación de un cuestionario a trece pacientes que vivían en el área descubierta del territorio. Resultados: la mayoría de los participantes relataron conocer el concepto de área descubierta, pero no sentirse perjudicados por vivir en un territorio descubierto. Sin embargo, coincidieron en pensar que debe haber cobertura en el territorio. Conclusión: los participantes conocen el concepto de área descubierta, piensan que es importante estar incluidos en el área de cobertura del equipo, pero no se sienten en desventaja.

DESCRIPTORES: atención primaria de salud; territorio; Estrategia de Salud de la Familia.

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INTRODUCTION

PHC represents an important gateway to health systems, including the Unified Health System (SUS). It is through this that the population makes the initial contact with the service. It harbors the potential for resolution, finding ways to solve most of the problems that arise. [1,2]

It is structured through principles: longitudinality, it guarantees the care of the individual over time, whether in relation to the follow-up of a specific disease until its cure, or in relation to the care of the patient throughout his life, supporting him in all phases of his existence; integrality, welcomes the user in their entirety, with high resolution of the demand and coordinator of care within the multidisciplinary perspective, referring to other levels of complexity when necessary. [1,2]

The importance of access to quality PHC services can be observed when evaluating the performance of primary care, contributing to a drop in infant mortality, greater immunization coverage and reduction of malnutrition. In addition, it reduces hospitalizations for PHC-sensitive conditions, cardiovascular mortality and improves quality of life, thus being a powerful tool for equity. [1,3,4]

In Brazil, primary care is provided through the Family Health Strategy (FHS) which for almost twenty years has organized the work process through the ascription of territory, that is, offering its services and care to a previously determined population. [5,6,7]

Users must be previously registered by professionals at the health unit closest to the neighborhood in which they reside. From this perspective, the work of the eSF, territorially delimited, is a way of guaranteeing continuous care and accountability for the same population, which allows the establishment of a bond, and thus the strengthening of ties between professionals and service users. [7]

The coverage of a population by the family health team makes it possible to closely monitor the reality of that territory. Thus, demographic and epidemiological data can be observed, vulnerabilities, priority problems and particularities regarding the grievances existing in that reality, with the important role of constant surveillance being performed, and therefore, carrying out a situational diagnosis and acting in a manner directed to the needs of that clientele. [5]

The linking of the population to the USFs is based on the registration of users with their teams, which is an important and constantly stimulated task, since through it it is possible to learn about the reality of the assisted population, facilitating contact about the delivery of exams or appointment bookings, for example. Despite its importance, the number of registrations in the country is still below ideal. [8]

A study pointed out that more than half of the country's population reported being registered in family health units, the rate being higher in the rural population compared to the urban population, and higher in the Northeast region and lower in the Southeast. [1]

It is observed that universality, an ethical doctrinal principle of the SUS that guarantees the right of access to the service to all, can be threatened if the bond is not stimulated, since access will not always be offered in a similar way to all populations, being able to reject the reverse care law, under the prism of equity, but under the format in which people do not receive assistance due to lack of coverage. [7,9]

Low coverage has been seen in the north and northeast regions of the country due to geographic difficulties or lack of health professionals, overlapping with structural problems in health equipment. On the other hand, easier access is seen in the South and Southeast regions, as well as in those families with a higher level of education. [7,9]

Although still below, there has been a great expansion in population coverage by the FHS in Brazil in recent years, with a growing trend in all five regions of the country, between 2006 and 2016, but unevenly between them. [3]

In 2012, according to the Ministry of Health, 95% of Brazilian municipalities had 33,404 teams, with the potential to cover 55% of the Brazilian population. Specifically for the city of João Pessoa, such numbers are extremely large, since according to the Ministry of Health, coverage by the family health strategy in December/2020 was 85.72% and for the state of Paraíba, in the same period, it was 97.83%. [10]

In addition to mere assistance coverage, it is important that the service offered is qualified, subject to evaluations and continuing education. This can be seen in the case of PHC in João Pessoa, through the implementation of Medical Residency Programs in Family and Community Medicine such as the one at the Federal University of Paraíba, has allowed the improvement of the service offered to the population, training specialist doctors. [11]

It is important to evaluate and monitor the evolution of FHS coverage to overcome the difficulties that limit the population's access to services, as well as to improve and qualify them. [12] Thus, how to perceive if the population understands and how they feel about not being part of the coverage area of some FHS team, even living close to the USF, and consequently, how this impacts their care, what difficulties they face in accessing consultations, exams, home visits. The poignant question is whether such a coverage number generates in users of a family health unit a feeling of guarantee of care. Thus, the present study aimed to evaluate the perception of the population entitled "influence", but which is attended at the Integrated Banking Family Health Unit in relation to access to services and devices offered by the health network, as well as tracing the epidemiological profile of these users.

METHOD

Cross-sectional, observational and descriptive research developed at USF Bancários Integrada, João Pessoa-PB. Data were collected through semi-structured interviews, based on a specific form, prepared by the research participants. The research sample consisted, for convenience, of thirteen (13) patients who lived in the area of influence of the health teams that work at

the aforementioned USF, who were approached during visits for care, and to those who agreed to participate in data collection and signed the free and informed consent form, the questionnaire was applied by the resident physician in family and community medicine at the USF in question, at times close to the care of that patient, during the month of December 2021. Users under 18 years of age, who did not accept to participate in the research, and who resided in an area covered by the USF were excluded from the research. The procedures for carrying out this research respected the guidelines and norms that regulate research involving human beings, defined in resolution nº 466, of December 12th, 2012 of the national health council, the project being approved by the Ethics Committee of the Faculty of Medical Sciences of Paraíba, under CAAE: 52641421.2.0000.5178. Data were analyzed descriptively, under a quantitative approach.

RESULTS

When tracing the epidemiological profile of the participants, it was noticed that they were between 21 and 74 years old, 54% declared themselves single, 15% married, 24% divorced and 7% widowed; the majority, 62% of them declared themselves white, and the other 38% brown. As for the level of education, 54% had high school and 46% had completed higher education, 62% were female and the remaining 38% were male. Regarding family income, the results: less than 1 minimum wage, 16%; 2 to 3 salaries, 38%; 4 to 6 salaries, 38% and more than 6 minimum salaries, 7%. 84% of the participants lived with other family members and, among the USF's territory of influence, 5 streets were mentioned in which they lived.

Regarding access to health services: 16% of people had frequent access to the private health network, 46% access it occasionally and 38% use the SUS exclusively. When asked about the frequency of access to the USF, 16% said it was the first time they sought it, while 69% reported attending it occasionally, around once every 6 months, and 16% said they used it frequently. And despite being residents of an uncovered area, 93% reported not having difficulties accessing the health service because they are in an area of influence, and 100% of them did not find it difficult to be attended when they sought the Health Unit for the first time, with only 7% claiming to have looked for other Units before discovering the one that would serve the territory in which they live.

In relation to accessing the SUS for the first time, almost all the participants indicated that they had no difficulty in doing so, and had no problem finding which FHU to look for, in line with what Garnelo et al. (2018) assessed, the evaluated users reported relative ease of access to the primary care service, with complaints regarding appointment scheduling, USF opening hours, and distance from home. 8

Regarding the concept of uncovered area or area of influence, 76% of people claimed to know its meaning, and all participants said they were familiar with the role of CHA, and of these, 76% did not feel harmed by living in territory not covered by these professionals. The 24% who said they felt at a loss because of this, narrated mainly the issue of ease of contact with the service and the more attentive and close care that could be offered. Only 7% said they needed a home visit from the team and felt they missed this service because it was part of an area without coverage. Still, 69% said they had lived in another territory that was covered by a health team, and of these, 55% reported noticing a difference in the relationship with the service because of this. Still, 76% knew people who are covered by USF Bancários, but most of these, 60% did not perceive any difference in care in relation to these people. Finally, 46% of the participants said they felt harmed by living in an open area and 93% thought that there should be a Community Health Agent on their street.

DISCUSSION

The results of the study showed that the profile of the participants was mostly single, white, with complete high school, who use the SUS as the main form of access to Health, despite having access at least occasionally to the private network. In addition, most people had already attended the USF, but they do so occasionally, to renew prescriptions or acute complaints.

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Despite being residents of an area of influence, most users reported knowing the role of CHA, but not feeling harmed at that moment for not having the work of these professionals. However, they agreed that these professionals should work on their streets and almost half of them reported that they think there are losses for living in an uncovered territory. The main justifications for stating that it is important to rely on the work of CHA and for the importance of living in an area covered by the Family Health teams were the possibility of more attentive care, as well as the belief that it would provide more proximity to the service, in addition to better care for family members who have chronic diseases or who are domiciled.

Opinions corroborated by the one described by Pereira and Barcellos (2006) in which the potential of the presence of ACS within the territory is highlighted, as a deep knowledge of the local reality, its weaknesses and strengths, being able to help guide the multidisciplinary work, 6 in addition to being possible to perceive the importance of home visits by the multidisciplinary team for the comprehensive care of those patients who are unable to go to the Units. [13]

Although they mentioned that they thought it was important to have a health team, most users said they did not feel harmed at that moment, which can be explained by the fact that most of the research participants were young patients, without comorbidities, who do not undergo chronic treatments and who need the health service punctually and sporadically, for whom closer care would apparently not be needed. However, the importance of primary care in reducing hospitalizations and deaths from causes sensitive to PHC is well established, and in improving the health indicators of a population, regardless of its profile, which can only be done with excellence with an adequate territorialization. [1,3,4,5] In addition, the area served by the USF in question covers a very heterogeneous population in terms of socioeconomic conditions and access to Health, not being, at least in part, a population strictly dependent on the SUS,

which can make them, in times of need, have access to private services, which end up reducing dependence on the public service and the feeling that they are not being harmed by this fragmented care.

CONCLUSION

Most of the participating users reported that they think they should be part of an area covered by the FHS and rely on the work of the CHA, for agreeing that there would be gains in the quality of care, although at that moment they did not feel greatly harmed by living in the discovered territory. The profile of the sample studied may have influenced the pattern of patients' responses, due to the fact that they are partially young patients, or without significant comorbidities, which can generate the feeling of not needing closer care.

For a better evaluation and diversification of reflections, it may be important to increase the number of participants in future studies, as well as the inclusion of users who live in an uncovered area, but who have mobility limitations, have chronic diseases without access to other health services, as well as patients and relatives of domiciled patients who need closer and continuous attention.

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